DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To:	Family Planning Clinics TAKE CHARGE Providers Managed Care Organizations	**Memorandum No: 06-99** **Issued:** December 29, 2006
From:	Douglas Porter, Assistant Secretary Health and Recovery Services Administration (HRSA)	**For information, contact:** 800.562.3022 or go to: http://maa.dshs.wa.gov/contact/prucontact.asp

Subject: HRSA-Approved Family Planning Provider Billing Instructions: Policy Clarification and 2007 Changes and Additions to Current Procedural Terminology (CPT®) Codes, Policies and Fee Schedules.

Effective for dates of service on and after January 1, 2007, unless otherwise noted, Health and Recovery Services Administration (HRSA) will:

- Begin using the Year 2007 Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) Level II code additions and deletions as discussed in this memorandum;
- Update the Family Planning Only and TAKE CHARGE Fee Schedule to include the new 2007 codes and fees; and
- Update and clarify various policies and payment rates.

Overview

- **All policies previously published remain the same unless specifically identified as changed in this memo.**

- Do not use CPT and HCPCS codes that are deleted in the "*Year 2007 CPT*" book and the "*Year 2007 HCPCS*" book for dates of service after December 31, 2006.

Fee Schedule

- You may view HRSA's Physician-Related Services and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Fee Schedules on-line at http://maa.dshs.wa.gov/RBRVS/Index.html

- For a paper copy of the fee schedule, see "How can I get HRSA's provider documents?" on page 4 of this memorandum.

Policy Updates

Retroactive to dates of service on and after November 1, 2006, HRSA has updated and clarified the *HRSA-Approved Family Planning Provider Billing Instructions* and Fee Schedule.

Maximum Allowable Fees

HRSA used the following resources in determining the maximum allowable fees for the Year 2007 additions:

- Year 2007 Medicare Physician Fee Schedule Data Base (MPFSDB) relative value units;
- Year 2007 Medicare Laboratory Fee Schedule; and
- Current Conversion Factors.

> **Note:** Due to its licensing agreement with the American Medical Association regarding the use of CPT codes and descriptions, HRSA publishes only the official brief description for all codes. Please refer to your current CPT book for full descriptions.

Added and Deleted CPT Codes

Effective for dates of service on and after January 1, 2007, HRSA has incorporated the CPT and HCPCS code updates into the January 1, 2007 Family Planning/TAKE CHARGE Fee Schedule. HRSA has updated coverage and fee schedules.

Injectable Drug Updates

HRSA is updating the Injectable Drug Fee Schedule for January 1, 2007. You may access this at http://maa.dshs.wa.gov. Click **Provider Publications/Fee Schedules**, click **Fee Schedules**, then scroll down to **Injectable Drug Fee Schedule**.

Billing Instructions Replacement Pages

Attached are updated replacement pages A.3 – A.6, B.1 – B.8, C.5 – C.6, C.11 – C.12, C.17 – C.30, D.1 – D.8, and E.11 – E.12 for HRSA's current *HRSA-Approved Family Planning Provider* Billing Instructions.

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing the WAMedWeb at http://wamedweb.acs-inc.com.

How can I get HRSA's provider documents?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

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Section G: Completing the 1500 Claim Form

Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its programs; however, HRSA's response is based solely on the information provided to the [HRSA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs. [WAC 388-502-0020(2)].

Who do I contact to obtain information on becoming a HRSA-Approved Family Planning Provider?

Family Planning program manager:
Phone: 360.725.1664; **or**

TAKE CHARGE program manager:
Phone: 360.725.1652

Who do I contact if I am an HRSA-approved Family Planning provider and I want to submit a change of address or ownership, or find out about the status of a provider application?

Provider Enrollment:
http://maa.dshs.wa.gov/provrel/ or
Phone: 866.545.0544 (toll free)

Who do I contact if I am a TAKE CHARGE provider and I want to submit a change of address, phone number, or fax number?

Family Planning program manager:
Phone: 360.725.1664; **or**

TAKE CHARGE program manager:
Phone: 360.725.1652

Where can I get the TAKE CHARGE Application DSHS form # 13-781?

To **download** DSHS forms, visit:
http://www1.dshs.wa.gov/msa/forms/eforms.html
scroll down to form # 13-781.

To **have a copy mailed**, contact:
DSHS Forms Management
Phone: 360.664.6047 or
Fax: 360.664.6186
Include in your request:

- Form number and name;
- Quantity desired;
- Your name and your office name; and
- Your full mailing address.

How do I obtain information regarding the Family Planning program?

Visit the Family Planning Resources link on HRSA's web site:
http://maa.dshs.wa.gov/familyplan/index.html

E-mail the Provider Relations unit:
providerinquiry@dshs.wa.gov

Family Planning program manager
Family Services Section
PO Box 45530
Olympia, WA 98504-5530
Phone: 360.725.1664

Which reproductive health services may an HRSA managed care client receive outside of the client's plan?

[Refer to WAC 388-532-100(2)]

Clients enrolled in an HRSA managed care plan may **self-refer** outside their plan for family planning*, abortions, and sexually transmitted disease-infection (STD-I) services to any of the following:

- An HRSA-approved Family Planning provider; or
- An HRSA-contracted local health department/STD-I clinic; or
- An HRSA-contracted provider who provides abortions; or
- An HRSA-contracted pharmacy (see HRSA's *Prescription Drug Program Billing Instructions*) for:

  √ Over-the-counter contraceptive supplies; and
  √ Contraceptives and STD-I related prescriptions from an HRSA-approved Family Planning provider or HRSA-contracting local health department/STD-I clinic.

* *Excludes sterilizations for clients 21 years of age and older.*

[WAC 388-532-140(2)]

When a client enrolled in a department-approved managed care plan self-refers **outside the plan** to either a department-approved family planning provider or a department-contracted local health department STD-I clinic, all laboratory services must be billed through the family planning provider or the health department that ordered the laboratory work.

When a client enrolled in a department-approved managed care plan obtains family planning or STD-I services from a department-approved family planning provider or a department-contracted local health department STD-I clinic that has a contract with the client's managed care plan, those services **must** be billed directly to the managed care plan.

What services are covered? [Refer to WAC 388-532-120]

- **Food and Drug Administration (FDA)-approved prescription contraception methods** (See HRSA's *Prescription Drug Program Billing Instructions)*

- **OTC contraceptives, drugs, and supplies**
  (See HRSA's *Prescription Drug Program Billing Instructions*)

- **Maternity-related services**
  (See HRSA's *Physician-Related Services Billing Instructions*)

- **Abortions**
  (See HRSA's *Physician-Related Services Billing Instructions*)

- **Sterilization** procedures that meet the requirements of HRSA's *Physician-Related Services Billing Instructions*, if the procedures are:

  √ Requested by the client; and
  √ Performed in an appropriate setting for the procedure(s).

> **Note:** The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days but no longer than 180 days prior to surgery.

Services for women who are seeking and needing contraception

Every female Medicaid client needing contraception and an annual exam is eligible for one comprehensive family planning preventive medicine visit every 11-12 months, if it is provided by a TAKE CHARGE provider. A Medicaid client who is sterilized or otherwise not at risk for pregnancy does not qualify for a comprehensive family planning preventive medical visit.

In addition to the reproductive health services listed in HRSA's *Physician-Related Services Billing Instructions*, HRSA covers all of the following reproductive health services:

- An initial or annual comprehensive family planning preventive medicine visit is allowed with a family planning diagnosis, once every 11-12 months.

  The comprehensive family planning preventive medicine visit includes the following:

  - A clinical breast examination and a pelvic examination;
  - Client-centered counseling that incorporates anticipatory guidance and risk factor reduction intervention regarding the prevention of unintended pregnancy;
  - May include a pap smear, according to current clinical guidelines; and

- STD-I screening and treatment as clinically indicated.

If the provider is an Infertility Prevention Project (IPP) provider, the Gonorrhea (GC) and Chlamydia (CT) test must be sent to a laboratory that has a Medicaid provider number instead of the non-Medicaid IPP laboratory.

For providers who have a delayed pelvic examination protocol, these services may be divided between two visits. See pages C.19 for more information about billing for a delayed pelvic examination.

Refer to CPT codes 99384 – 99386 and 99394 – 99396 for services provided at the annual comprehensive family planning preventive medicine visit. *Only TAKE CHARGE providers can bill these preventive codes.*

Note: Historically, HRSA has paid providers for preventive examinations under the EPSDT program for clients who are 20 years of age and younger and for Developmentally Delayed (DD) clients. Under the terms of the TAKE CHARGE Waiver, only TAKE CHARGE providers can bill for an annual comprehensive family planning preventive medicine visit using Preventive Medicine Current Procedural Terminology (CPT™) codes for women ages 13 through menopause. Clients receiving this service must be seeking and needing contraception.

Note: The annual comprehensive family planning preventive medicine visit cannot be billed on the same date of service with a cervical, vaginal and breast cancer examination (G0101) or an office visit.

- **Cervical, vaginal, and breast cancer screening examination,** once every 11-12 months as medically necessary. The screening HCPCS code G0101 must be billed with one of the following diagnosis codes for women who are not needing or seeking contraception:

  √ V72.31 routine gynecological exam with Pap cervical smear;
  √ V76.47 routine vaginal Pap smear; or
  √ V76.2 cervical Pap smear without general gynecological exam.

  You may also bill an office visit on the same day using modifier 25, when you provide a separately identifiable Evaluation and Management (E/M) service.

Screening and treatment for STD-I, including laboratory tests and procedures for

√ HIV testing use CPT code 86703.

- **Education and supplies** for FDA-approved contraceptives, natural family planning, and abstinence

- **Mammograms** for clients 40 years of age and older, once every 12 months. Clients 39 years of age and younger require prior authorization for mammograms (see *Physician-Related Services*, Section I).

- **Colposcopy** and related medically necessary follow-up services.

Note: HIV testing and counseling is **not** a covered service for TAKE CHARGE and Family Planning Only clients.

Family Planning Only Program

What is the purpose of the Family Planning Only program?

[Refer to WAC 388-532-500]

The purpose of the Family Planning Only program is to provide family planning services at the end of a pregnancy to women who received medical assistance benefits during their pregnancy.

The primary goal of the Family Planning Only program is to prevent an unintended subsequent pregnancy. Women receive this benefit automatically regardless of how or when the pregnancy ends. This 10-month benefit follows HRSA's 60-day postpregnancy coverage. **Men are not eligible for the Family Planning Only program.**

When the pregnant woman applies for medical assistance, the Community Services Office (CSO) worker identifies the woman's expected date of delivery. At the end of the 60-day postpartum period, the woman automatically receives an informational flyer and a Medical ID Card stating *FAMILY PLANNING ONLY*. If her pregnancy ends for any reason other than delivery, she **must** notify the CSO to receive the Family Planning Only Medical ID Card.

Provider Requirements [Refer to WAC 388-532-520]

To be paid by HRSA for services provided to clients eligible for the Family Planning Only program, physicians, advanced registered nurse practitioners (ARNPs), and HRSA-approved Family Planning providers must:

- Meet the requirements in Chapter 388-502 WAC, *Administration of Medical Programs - Provider* rules;
- Provide only those services that are within the scope of their licenses;
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request; and
- Supply or prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.

Note: Providers who are unable to meet all of the provider requirements must refer the client to an appropriate provider.

Who is eligible? [WAC 388-532-510]

A woman is eligible for Family Planning Only services if:

- She received medical assistance benefits during her pregnancy; or
- She is determined to be eligible for a retroactive period (see *Definitions* section) covering the end of the pregnancy.

What services are covered? [Refer to WAC 388-532-530]

Every female Medicaid client needing contraception and an annual exam is eligible for one comprehensive family planning preventive medicine visit every 11-12 months, if it is provided by a TAKE CHARGE provider. A Medicaid client who is sterilized or otherwise not at risk for pregnancy does not qualify for a comprehensive family planning preventive medicine visit.

Note: All services provided to Family Planning Only clients must have a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis code in the V25 series, excluding V25.3).

HRSA covers all of the following services under the Family Planning Only program:

- An initial or annual comprehensive family planning preventive medicine visit is allowed with a family planning diagnosis, once every 11-12 months.

  The comprehensive family planning preventive medicine visit includes the following:

  - A clinical breast examination and a pelvic examination;
  - Client-centered counseling that incorporates anticipatory guidance and risk factor reduction intervention regarding the prevention of unintended pregnancy; and
  - May include a pap smear according to current clinical guidelines.

  - For women between the ages of 13 and 25, this visit may also include routine Gonorrhea (GC) and Chlamydia (CT) testing and treatment.

  If the provider is an Infertility Prevention Project (IPP) provider, the GC and CT test must be sent to a laboratory with a Medicaid provider number instead of the non-Medicaid IPP laboratory.

  For providers who have a delayed pelvic examination protocol, these services may be divided between two visits. See pages C.19 for more information about billing for a delayed pelvic examination.

  Refer to CPT codes 99384 – 99386 and 99394 – 99396 for services provided at the annual comprehensive family planning preventive medicine visit. *Only TAKE CHARGE providers can bill these preventive codes for Family Planning Only clients.*

- **Cervical, vaginal, and breast cancer screening examination,** once every 11-12 months as medically necessary. The screening HCPCS code G0101 must be billed with an ICD-9 CM diagnosis code within the V25 series, excluding V25.3. The examination must be:

  √ Provided according to the current clinical guidelines; and
  √ Conducted at the time of an office visit with a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis code within the V25 series, excluding V25.3).

  Note: The annual comprehensive family planning preventive medicine visit cannot be billed on the same date of service with a cervical, vaginal and breast cancer examination (G0101) or an office visit.

- An office visit directly related to a family planning problem when medically necessary.

- **FDA-approved prescription and nonprescription contraceptives** as provided in Chapter 388-530 WAC, including, but not limited to, the following items:

  √ Birth control patch
  √ Birth control pills
  √ Birth control vaginal ring
  √ Diaphragm and cervical cap and cervical sponge
  √ Emergency contraception
  √ Injectable and implantable hormonal contraceptives
  √ Intrauterine devices (IUDs)
  √ Male and female condoms
  √ Spermicides (foam, gel, suppositories, and cream)

  Note: Pap smears, while not technically related to any contraceptive method, may be provided according to the current standard of care and schedule. Providers must have and follow a Pap smear protocol based on the guidelines of a nationally recognized organization such as the American College of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), or the U.S. Preventive Services Task Force (USPSTF).

- **Sterilization** procedures that meet the requirements of HRSA's *Physician-Related Services Billing Instructions*, if the procedures are:

  √ Requested by the client; and
  √ Performed in an appropriate setting for the procedure.

  Note: The surgeon's initial office visit for sterilization is covered when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days but no longer than 180 days prior to surgery.

- **Screening and treatment for STD-I**, including laboratory tests and procedures **only** when the screening and treatment are:

  √ A part of the comprehensive family planning preventive medicine visit for women 13-25 years of age (only GC or CT); or
  √ Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis code in the V25 series, excluding V25.3); **and**
  √ Medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.

- **Education and/or supplies** for FDA-approved contraceptives, natural family planning, and abstinence.

What drugs and supplies are paid under the Family Planning Only program?

HRSA pays for the family planning-related drugs and contraceptives within the following therapeutic classifications:

Contraceptives and supplies that can be dispensed from a HRSA-approved family planning clinic.	**Family planning related drugs and supplies that can be dispensed from a pharmacy.**
Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, implantable, systemic Condoms Diaphragms/cervical caps Intrauterine devices Foams, gels, sponge, spermicides, vaginal film, creams. Azithromycin	Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, implantable, systemic Condoms Diaphragms/cervical caps Intrauterine devices Foams, gels, spermicides, vaginal film, creams. Vaginal antifungals Vaginal Sulfonamides Vaginal Antibiotics Tetracyclines Macrolides Antibiotics, misc. other Quinolones Cephalosporins – 1st generation Cephalosporins – 2nd generation Cephalosporins – 3rd generation Absorbable Sulfonamides Nitrofuran Derivatives Antifungal Antibiotics Antifungal Agents Anaerobic antiprotozoal – antibacterial agents
	* Antianxiety Medication – Before Sterilization Procedure Diazepam Alprazolam
	* Pain Medication – After Sterilization Procedure Acetaminophen with Codeine #3 Hydrocodone Bit/ Acetaminophen Oxycodone HCl/Acetaminophen 5/500 Oxycodone HCl/ Acetaminophen

* Selected drugs are copied from Numbered Memorandum 05-05 HRSA.

Over-the-counter, non-prescribed contraceptive supplies (e.g., condoms, spermicidal foam, cream, gel, etc.,) may also be obtained in a 30-day supply through a pharmacy or a family planning clinic with a Medical ID Card.

Hormonal Contraceptives Dispensed from HRSA-Approved Family Planning Clinics:

For fee-for-service clients, hormonal contraception must be dispensed at a minimum of three cycles/months. A maximum of 13 cycles may be dispensed on the same day. If the hormonal contraception is dispensed for less than three months/cycles, there must be documentation in the chart stating the reason the why only one or two cycles were dispensed.

Hormonal Contraceptive Prescriptions filled at the pharmacy.

HRSA's Point-of-Sale system currently cannot fill a contraception prescription for more than a three month supply at one time. We are working on system changes to allow refills for up to a 12 month supply. Until further notice, you must dispense three months/cycles unless the prescriber writes a prescription for less than three months/cycles.

Managed care clients will receive their hormonal contraceptives according to the terms set by their managed care plans.

Note: All services and prescriptions billed for Family Planning Only clients **must** have a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis codes within the V25 series, excluding V25.3).

What services are *not* covered? [WAC 388-532-540]

Medical services are not covered under the Family Planning Only program unless those services are:

- Performed in relation to a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis code within the V25 series, excluding V25.3); and
- Medically necessary for clients to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Abortions are **not** covered under the Family Planning Only program.

Note: If the client's DSHS Medical ID card says *Family Planning Only* but she is pregnant, please refer the client to her local Community Services Office (CSO) to be evaluated for a possible change in her Medical Assistance program that would enable her to receive full scope of care.

Inpatient Services: HRSA does not pay for inpatient services under the Family Planning Only program. However, providers may request an exception to this policy on a case-by-case basis for inpatient costs incurred as a result of complications arising from covered family planning services. If this happens, providers of inpatient services must submit a complete report to HRSA detailing the circumstances and conditions that caused the need for the inpatient services in order for HRSA to consider payment under WAC 388-501-0160.

A complete report includes:

- A copy of the billing (UB-92, 1500 Claim Form);
- Letter of explanation;
- Discharge summary; and
- Operative report (if applicable).

Fax the complete report to HRSA Division of Medical Benefits and Case Management at 360.586.1471.

Reimbursement

[Refer to WAC 388-532-550, WAC 388-530-1425, and WAC 530-1700(4)]

Fee Schedule: HRSA limits reimbursement under the Family Planning Only program to visits and services listed on the Fee Schedule (see section D) that:

- Have a primary focus and diagnosis of family planning as determined by a qualified, licensed medical practitioner (i.e., ICD-9-CM diagnosis code within the V25 series); and

- Are medically necessary for the clients to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Department-Approved Family Planning Clinics that Dispense Contraception:

Must comply with WAC 388-530-1700(4) Pharmacy Services.

- **For services**: Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payment is either your *usual and customary fee* or HRSA's maximum allowable fee, whichever is less.

- If an HRSA fee schedule lists a drug or item as "actual acquisition cost," the provider must bill its actual acquisition cost and not a usual and customary fee or maximum allowable fee.

- **For drugs purchased under the Public Health Services Act**: Providers must comply with Pharmacy Services WAC 388-530-1425.

WAC 388-530-1425
(1) Drugs purchased under section 340B of the Public Health Service (PHS) Act can be dispensed to medical assistance clients only by PHS-qualified health facilities. These medications must be billed using the actual acquisition cost (AAC) of the drug plus the appropriate dispensing fee.

(2) Providers dispensing drugs under this section are required to submit their valid HRSA provider number(s) to the PHS Health Resources and Services Administration, Office of Pharmacy Affairs. This requirement is to ensure that claims for drugs dispensed under the Public Health Service (PHS) Act and paid by HRSA are excluded from the drug rebate claims that are submitted to the manufacturers of the drugs.

- **For other contraceptives, drugs, drug supplies and devices not purchased under Public Health Services Act:** Bill HRSA your usual and customary fee. Reimbursement is your usual and customary fee or the department's maximum allowable fee, whichever is less. [Refer to WAC 388-530-1050]

- Any non-contraceptive take-home drugs dispensed at a family planning clinic are not reimbursable.

When can providers who are not TAKE CHARGE providers furnish services for TAKE CHARGE clients?

[WAC 388-532-730(2)]

HRSA providers (e.g., pharmacies, laboratories, surgeons performing sterilization procedures) who are not TAKE CHARGE providers may furnish family planning ancillary services (see *Definitions & Abbreviation* section) to eligible TAKE CHARGE clients.

HRSA pays for these services under the rules and fee schedules applicable to the specific services provided under HRSA's other programs.

Note: The family planning provider's partnership with pharmacists is especially critical since they provide immediate access to methods not received at the TAKE CHARGE agency/clinic.

Who is eligible? [WAC 388-532-720(1) and (2)]

The TAKE CHARGE program is for both men and women. To be eligible for the TAKE CHARGE program, applicants must:

- Attest that they are a United States (U.S.) citizen, U.S. national, or qualified alien eligible for Medicaid as described in chapter 388-424 WAC;
- Be a resident of the state of Washington as described in WAC 388-468-0005;
- Have income at or below 200% of the federal poverty level (FPL) as described in WAC 388-478-0075;
- Apply voluntarily for family planning services with a TAKE CHARGE provider; and
- Need family planning services but have no family planning coverage through another HRSA program or health insurance plan.

Note: Clients who currently are pregnant, sterilized, in the military on active duty, or incarcerated are not eligible for TAKE CHARGE.

A client may enroll in TAKE CHARGE at one TAKE CHARGE provider's office and receive services at a different TAKE CHARGE provider's office. Some clients may apply for TAKE CHARGE in order to obtain contraceptives appropriately prescribed by a non-TAKE CHARGE provider. TAKE CHARGE providers must assist these clients with enrollment so that they may go to a pharmacy to fill their prescription using their TAKE CHARGE Medical ID card. TAKE CHARGE providers have the obligation to help all potentially eligible clients enroll in the program, regardless of where they choose to receive services.

How long can a client receive TAKE CHARGE coverage?

[WAC 388-532-720(3)]

A client is authorized for TAKE CHARGE coverage for one year from the date HRSA determines eligibility, or for the duration of the demonstration and research program, whichever is shorter, as long as the client continues to meet the eligibility criteria.

When a client reapplies for TAKE CHARGE, HRSA may renew the coverage for additional periods of up to one year each, or for the duration of the demonstration and research program, whichever is shorter.

Note: Always check Medical Eligibility Verification (MEV) to make sure that a client's one year eligibility for TAKE CHARGE is still valid or that the client is not on another HRSA program that covers family planning services.

How do I help a client apply for TAKE CHARGE?

Applicants must apply in person for TAKE CHARGE at an HRSA-approved TAKE CHARGE clinic or agency. Client eligibility is determined at the state level. **You, the provider,** must provide the applicant with:

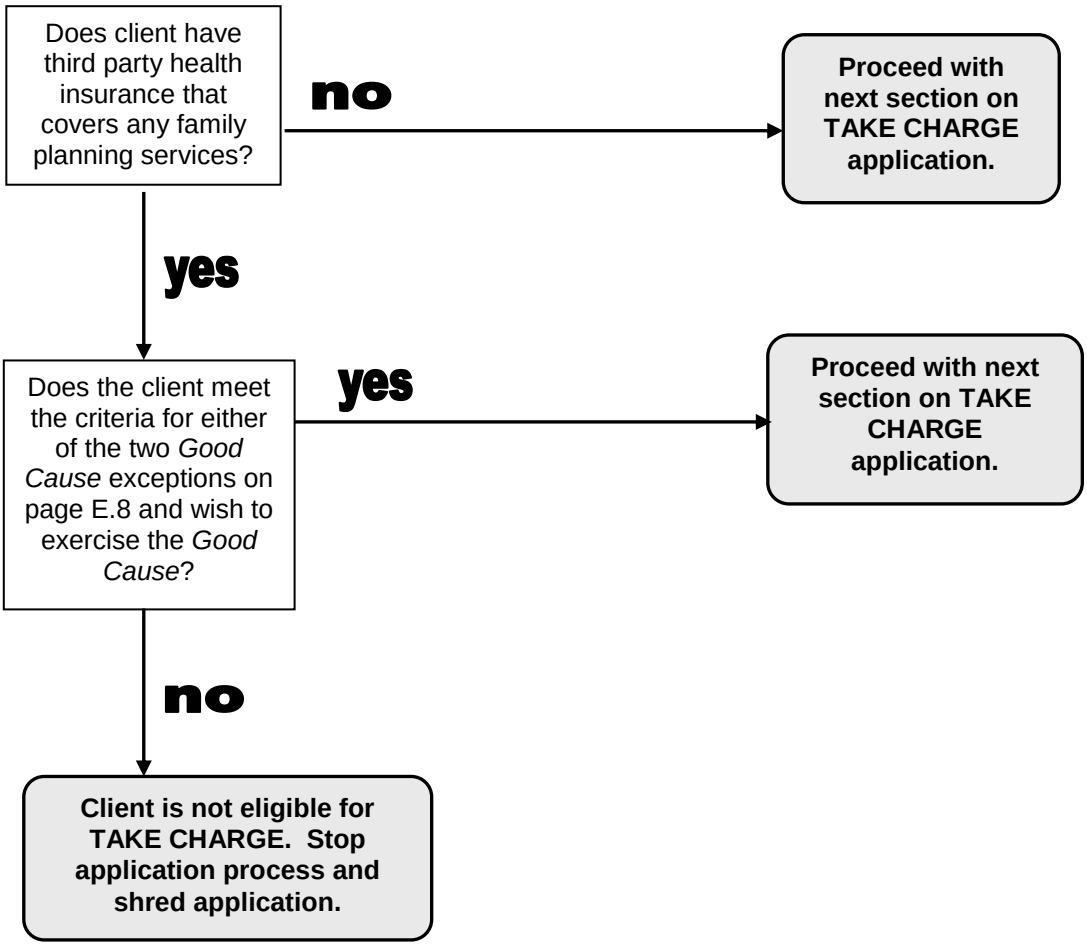
- A TAKE CHARGE client application, including an affidavit to establish U.S. citizenship, if client claims U.S. citizenship, and citizenship has not previously been established by HRSA.

- Application assistance in completing the document prior to submitting the TAKE CHARGE client application to HRSA for eligibility determination.

The completed initial or recertification application must be entered into the TAKE CHARGE application database no later than 20 working days from the date of the client's signature.

Note: The application must be completed at the provider's office. You may not send the application home with the client to complete, nor may you mail the application to the client.

TAKE CHARGE Eligibility for Clients with Health Insurance



Citizenship Requirement

U.S. citizens or U.S. nationals qualify for TAKE CHARGE. All clients must sign an affidavit claiming citizenship **and** provide a photo ID unless citizenship and identity can be established by the following documents: Keep copies of these documents with the client's TAKE CHARGE application.

The following documents provide proof of citizenship and identity:

- U.S. passport; or
- Certificate of Naturalization; or
- Certificate of Citizenship; or
- Tribal membership card with photo.

These documents provide proof of citizenship only:

- An official state/county U.S. birth certificate; or
- Other certification of birth issued by the Department of State; or
- U.S. citizen ID card; or
- Final adoption decree in the U.S.; or
- Evidence of civil service employment by the U.S. government before June 1976; or
- Official military record of service that shows a U.S. place of birth.

Note: A "hospital" birth certificate is considered by the federal government to be a souvenir and does not meet the federal requirement.

These documents provide proof of identity only:

- A current state driver's license with individual's photo; or
- A state identity card with individual's photo; or
- A U.S. American Indian/Alaska Native tribal document; or
- Military identification card (non-active or dependent) with individual's photo; or
- School identification card.

Note: **Only for children** under the age of 16, make a note in the chart if no photo identification is available.

If the client does not have proof of U.S. citizenship with them when enrolling in TAKE CHARGE, then the provider must have the client complete an affidavit of U.S. citizenship (DSHS form #13-789). This affidavit must be kept in client's chart until HRSA requests this information.

The provider must make a copy of the client's legal, permanent U.S. Citizenship and Immigration Services (USCIS) paperwork and the date the client permanently entered the U.S. The USCIS paperwork must be faxed to the TAKE CHARGE Eligibility Unit for eligibility determination at 866.841.2267. The provider must keep a copy of these documents and the photo ID with the client's application.

Illegal or undocumented persons are not eligible for TAKE CHARGE.

What services are covered? [Refer to WAC 388-532-740]

Every female Medicaid client needing contraception and an annual exam is eligible for one comprehensive family planning preventive medicine visit every 11-12 months, if it is provided by a TAKE CHARGE provider. A Medicaid client who is sterilized or otherwise not at risk for pregnancy does not qualify for a comprehensive family planning preventive medicine visit.

Note: The purpose of the TAKE CHARGE program is to prevent unintended pregnancies. All services provided under TAKE CHARGE must be related to the prevention of unintended pregnancy.

HRSA covers all of the following TAKE CHARGE services for **women**:

- An initial or annual comprehensive family planning preventive medicine visit is allowed with a family planning diagnosis, once every 11-12 months.

The comprehensive family planning preventive medicine visit includes the following:

- A clinical breast examination and a pelvic examination;
- Client-centered counseling that incorporates anticipatory guidance and risk factor reduction intervention regarding the prevention of unintended pregnancy; and
- May include a pap smear according to current clinical guidelines.

- For women between the ages of 13 and 25, this visit may also include routine Gonorrhea (GC) and Chlamydia (CT) testing and treatment.

If the provider is an Infertility Prevention Project (IPP) provider, the GC and CT test must be sent to a laboratory with a Medicaid provider number instead of the non-Medicaid IPP laboratory.

For providers who have a delayed pelvic examination protocol, these services may be divided between two visits. See pages C.19 for more information about billing for a delayed pelvic examination.

Refer to CPT codes 99384 – 99386 and 99394 – 99396 for services provided at the annual comprehensive family planning preventive medicine visit. *Only TAKE CHARGE providers can bill these preventive codes for Family Planning Only clients.*

- **Cervical, vaginal, and breast cancer screening examination,** once every 11-12 months as medically necessary. The screening HCPCS code G0101 should be billed with ICD-9-CM diagnosis codes within the V25 series, excluding V25.3. The examination must be:

  √ Provided according to the current clinical guidelines; and
  √ Conducted at the time of an office visit with a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis code within the V25 series, excluding V25.3).

  Note: The annual comprehensive family planning preventive medicine visit cannot be billed on the same date of service with a cervical, vaginal and breast cancer examination (G0101) or an office visit.

- One session of **application assistance** per client, once every 12 months.

- An office visit directly related to a family planning problem when medically necessary.

- **FDA-approved prescription and nonprescription contraceptives** as provided in Chapter 388-530 WAC, including, but not limited to, the following items:

  √ Birth control patch;
  √ Birth control pills;
  √ Birth control vaginal ring;
  √ Diaphragm and cervical cap and cervical sponge;
  √ Emergency contraception.
  √ Injectable and implantable hormonal contraceptives;
  √ Intrauterine devices (IUDs);
  √ Male and female condoms;
  √ Spermicides (foam, gel, suppositories, and cream); and

  Note: Pap smears, while not technically related to any contraceptive method, may be provided according to the current standard of care and schedule. Providers must have and follow a Pap smear protocol based on the guidelines of a nationally recognized organization such as the American College of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), or the U.S. Preventive Services Task Force (USPSTF).

- Sterilization procedures that meet the requirements found in these billing instructions and *HRSA's Physician-Related Billing Instructions*, if the services are:

  √ Requested by the TAKE CHARGE client; and
  √ Performed in an appropriate setting for the procedure.

  Note: The surgeon's initial office visit for sterilization is covered if performed more than one day prior to the surgery, when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days but no longer than 180 days prior to surgery.

- **Delayed Pelvic Visits**

Many clinics have protocols for clients who wish to initiate contraception and delay their pelvic exam. TAKE CHARGE providers may provide other components of the physical exam, contraceptive counseling, contraception, and schedule the pelvic examination for a subsequent visit. See the following tables for appropriate billing procedures for delayed pelvic visits.

Delayed Pelvic Visits – New Client

Visit	Performed by	Billing codes
First clinic visit for an initial or annual gynecological visit that includes detailed history, physical exam (excluding pelvic exam) counseling, contraceptive choice and contraceptive start.	ARNP, PA, MD	Preventive code 99384 – 99386 with modifier 52.
Subsequent (Different date of service than initial visit) This visit includes the initial/annual women's pelvic and breast exam (may also include Pap smear) and evaluation of client's satisfaction and compliance with chosen birth control method.	ARNP, PA, MD	Bill code G0101. Must be billed with a diagnosis from V25 series, *excluding V25.3*

Delayed Pelvic Visits – Established Client

Visit	Performed by	Billing codes
First clinic visit for an initial or annual gynecological visit that includes detailed history, physical exam (excluding pelvic exam) counseling, contraceptive choice and contraceptive start.	ARNP, PA, MD	Preventive code 99394 – 99396 with modifier 52.
	RN, LPN, medical assistant, certified nurse assistant or a trained and experienced health educator.	99211
Subsequent (Different date of service than initial visit) This visit includes the initial/annual women's pelvic and breast exam (may also include Pap smear) and evaluation of client's satisfaction and compliance with chosen birth control method.	ARNP, PA, MD	Bill code G0101. Must be billed with a diagnosis from V25 series, *excluding V25.3.*

- **Screening and treatment for STD-I**, including laboratory tests and procedures **only** when the screening and treatment are:

  √ A part of the comprehensive family planning preventive medicine exam for women 13-25 years of age (GC and CT only); or

  √ Performed in conjunction with and at the initial or annual comprehensive family planning preventive medicine visit and have a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis code within the V25 series, excluding V25.3); **and**

  √ Medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.

- **Education and/or supplies** for FDA-approved contraceptives, natural family planning, and abstinence.

HRSA offers all of the following TAKE CHARGE services for **men**:

Men who are specifically seeking family planning services such as sterilization, and/or contraceptive supplies (such as condoms and spermicides) for the purposes of preventing unintended pregnancy may be enrolled in TAKE CHARGE.

Note: TAKE CHARGE offers very limited services to men. Unless related to and necessary for sterilization, no office visits or physical exams are covered. No STD screening or treatment is covered unless related to and necessary for a sterilization procedure. HIV counseling and testing are not covered under TAKE CHARGE.

- One session of application assistance once every 12 months for those male clients specifically seeking family planning services.

- FDA-approved nonprescription contraceptives including spermicides and male and female condoms.

- Education and counseling for risk reduction for those male clients whose female partners are at risk for unintended pregnancy. (See pages C.21 – C.25 for the parameters for this service.)

- Sterilization procedures that meet the requirements found in these billing instructions and HRSA's *Physician-Related Services Billing Instructions*, if the service is:

    - Requested by the TAKE CHARGE client; and
    - Performed in an appropriate setting for the procedure.

Note: The surgeon's initial office visit for sterilization is covered if performed more than one day prior to the surgery when billed with ICD-9-CM diagnosis code V25.2. The federally mandated sterilization consent form must be filled out at least 30 days, but no longer than 180 days prior to the surgery.

Education and Counseling for Risk Reduction (ECRR)

The cornerstone of the TAKE CHARGE program is client-centered education and counseling service designed to strengthen decision making skills and support a client's safe, effective and successful use of the chosen contraceptive method.

For Women

Prior to November 1, 2006, ECRR was a standalone service with a separate billing code. The service is now offered as part of the annual comprehensive family planning preventive medicine visit. This comprehensive family planning preventive medicine visit focusing on the prevention of unintended pregnancy should be client-centered. There are some women who have a history of consistent and effective use of their contraceptive method. If, at the time of their visit, all indications are that they will continue to use contraceptives successfully, then these clients will need **minimal** counseling.

Some clients are generally very satisfied and successful with their chosen method but may have an occasional problem or lapse with their method that could result in them being at moderate risk for unintended pregnancy. These clients at **moderate** risk need some counseling and help with strategizing about back-up methods.

There are other **high risk** clients who have significant problems that interfere with their ability to use contraceptives consistently, effectively or successfully. These clients are at significantly increased risk for an unintended pregnancy and often need lengthy counseling and referrals for psycho-social issues that complicate their lives and their ability to use contraception.

The reimbursement for the annual comprehensive family planning preventive medicine visit that includes education and risk reduction counseling for unintended pregnancy is the same regardless of the risk of unintended pregnancy. For clients at high risk of contraceptive failure and unintended pregnancy, bill using the modifier SK to enable HRSA to evaluate the reimbursement of the preventive codes. See page E.1 in the *Billing* section for more information about the annual comprehensive family planning preventive medicine visit.

ECRR as part of the annual comprehensive family planning preventive medicine visit must be provided by one of the following TAKE CHARGE providers:

- Physician;
- Advanced Registered Nurse Practitioner (ARNP);
- Physician Assistant; or
- Registered Nurse, Licensed Practical Nurse or a trained and experienced health educator or medical assistant or certified nursing assistant when used for assisting and augmenting the above listed clinicians.

> **Note:** The counseling intervention must be clearly documented in the client's chart, with detailed information that would allow for a meaningful, well-informed, follow-up visit.

For Men

Men who are seeking family planning services and whose female sexual partners are at moderate to high risk for unintended pregnancy are eligible for one session of ECRR once every 12 months.

Men whose partners have had a tubal ligation or are using an IUD, *Depo-Provera* or *Implanon* are not eligible for ECRR services.

ECRR is not to be billed automatically for every male seen by a TAKE CHARGE provider. The reimbursement should not be used to cover the cost of providing other reproductive health services for men, including STD counseling, testing and treatment, which are not covered by TAKE CHARGE. HRSA will closely monitor the provision of this service to men.

i. Education and counseling for risk reduction is offered as a standalone counseling session, once every 12 months.

Bill this service using CPT code 99401 with a FP modifier.

Note: The only office visit that can be billed on the same day as ECRR is the initial preoperative sterilization visit. TAKE CHARGE offers very limited services to men.

ii. ECRR must be appropriate and individualized to the client's needs, age, language, cultural background, risk behaviors, and psychosocial history.

iii. ECRR must be provided by one of the following TAKE CHARGE providers:

- ✓ Physician;
- ✓ Advanced Registered Nurse Practitioner (ARNP);
- ✓ Physician Assistant; or
- ✓ Registered Nurse, Licensed Practical Nurse or a trained and experienced health educator or medical assistant or certified nursing assistant when used for assisting and augmenting the above listed clinicians.

Note: The counseling intervention must be clearly documented in the client's chart with detailed information that would allow for a meaningful, well-informed follow-up visit.

Components

Five critical components are a part of the ECRR intervention. Integrate these five components into the counseling process by following the client's lead. Individual components may overlap with the other components. For high-risk clients, you must have addressed and documented all of the components by the close of the client/provider interaction.

Component A: Help the client (male or female) critically evaluate which contraceptive method is most acceptable and which method can most effectively be used.

- Focus first on the client's choice of method;
- Assess and clarify knowledge, assumptions, misinformation, and myths about their chosen method(s);
- Describe method benefits, including non-contraceptive benefits;
- Address potential side effects and health risks;
- Provide written materials that are culturally sensitive, clear, relevant, and easy to understand; and
- Provide a telephone number to call if the client has questions.

Component B: Assess and address other client personal considerations, risk factors, and behaviors that impact the use of contraception.

At a minimum, assess the following:

- History of abuse;
- Current exploitation or abuse;
- Current living situation;
- Need for confidentiality; and
- Make community referrals as necessary (e.g., domestic violence shelters and hotlines, food bank, mental health, substance abuse, other primary care needs).

Component C: Facilitate discussion of the male role in successful use of chosen contraceptive method, as appropriate (for him or for his female partner).

- With both female and male clients, assess and address partner issues (e.g., attitudes about birth control methods and how much the partner will be involved);
- Reinforce male involvement in pregnancy prevention; and
- Discuss male's role in supporting a partner's use of an individual method, as appropriate.

Component D: Facilitate the client's contingency planning (the "back-up method") regarding the client's use of contraception, including planning for emergency contraception.

- Address side effects of the client's chosen method, and make sure the client knows what to do if there are side effects;
- Discuss back-up methods with the client;
- Provide information about access to emergency contraception as it relates to errors or problems with the chosen method; and
- Provide a telephone number for the client to call with questions or concerns.

Component E: When medically necessary, schedule follow-up appointments for birth control evaluation at or before 3 months, or as appropriate for the method chosen.

- Address questions about method use and follow-up appointment, as needed;
- Reinforce positive contraceptive and other self-protective behaviors; and
- Follow up on any community referrals, as necessary.

Determining if a client is at increased risk for unintended pregnancy

Clients can have just one factor in their life that can put them at increased risk for pregnancy, but most often risk factors occur in clusters. Below is a list (not all-inclusive) of some of the factors as they relate to the previously described components that would give indicate a client will likely need some in-depth education and counseling to support the safe, effective and successful use of the chosen contraceptive method.

When charting both the client's history and counseling intervention, make sure that the chart is detailed and thorough. This will facilitate a more meaningful and effective follow-up at the client's next visit, whether you see the client again or another provider sees the client.

Risk by Component

1. Method

At Risk	Not at Risk
Ambivalent about using birth control	Has successful method and wants to continue
Ambivalent about having sex	Already knowledgeable and motivated
Fearful/concerned about side effects	Easy access (teen clinic nearby or at school)
Trouble reading/understanding written materials	Easy to use
No partner support	Goal oriented and will not let anything get in the way (e.g. college, business venture, etc.)
Pattern of no follow-through previous birth control methods	Confident; self-assured
Wants method that has contraindications (e.g., smoker wants pill)	Fear driven
Younger teens	
Doesn't believe she can get pregnant (or that he can get someone pregnant)	
Ambivalent about preventing pregnancy	

2. Partner

At Risk	Not at Risk
Multiple partners	Involved partner/interested
Lack of communication	Supportive partner
Abusive partner	Communicative partner
Drug-using partner	Monogamous or long term partner
Controlling partner	Trustworthy
Unsupportive/uninvolved partner	Responsible
Apathetic	Partner comes to appointment
Partner not willing to help with cost	Impotent
	Information seeking
	Partner uses consistent method
	Offers financial support

3. Personal Considerations

At Risk	Not at Risk
Low literacy level/education level	Stable living environment
Transportation issues/other access issues	No negative history of abuse
Confidentiality of method	Determination/intent not to become pregnant
Substance abuse	
Abusive relationship	Good support system
History of sexual abuse	Positive peer pressure
Relationship status (length, etc.)	
Inability to meet basic needs	
Living conditions	
Low self-esteem	
No life goals (goals for future)	
Apathetic about future	
Mental health issues	
Maturity level	
Age at first intercourse	
Number of times pregnant	
Cultural beliefs	
Negative peer pressure	
Family history of teen pregnancy	

4. Back-up

At Risk	Not at Risk
Mental illness	(Exact opposite of risk characteristics listed on the left.)
Developmental delays	
Substance abuse	
Transportation issues/other access issues	
Uncooperative partner	
Has to seek contraception in secret	
Personal/religious beliefs (i.e., emergency contraception)	
Has misinformation	
Allergies	
Ambivalence about sex/contraception	
Assertive	

What drugs and supplies are paid under the TAKE CHARGE Program?

HRSA pays for the family planning-related drugs and contraceptives within the following therapeutic classifications:

Contraceptives and supplies that can be dispensed from a HRSA-approved family planning clinic.	**Family planning-related drugs and supplies that can be dispensed from a pharmacy.**
Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, implantable, systemic Vaginal lubricant preparations Condoms Diaphragms/cervical caps Intrauterine devices Foams, gels, sponge, spermicides, vaginal film, creams. Azithromycin	Oral contraceptives Contraceptives, injectables Contraceptives, transdermal Contraceptives, intravaginal Contraceptives, implantable, systemic Vaginal lubricant preparations Condoms Diaphragms/cervical caps Intrauterine devices Foams, gels, spermicides, vaginal film, creams. Vaginal antifungals Vaginal Sulfonamides Vaginal Antibiotics Tetracyclines Macrolides Antibiotics, misc. other Quinolones Cephalosporins – 1st generation Cephalosporins – 2nd generation Cephalosporins – 3rdt generation Absorbable Sulfonamides Nitrofuran Derivatives Antifungal Antibiotics Antifungal Agents Anaerobic antiprotozoal – antibacterial agents
	* Antianxiety Medication – Before Sterilization Procedure Diazepam Alprazolam
	* Pain Medication – After Sterilization Procedure Acetaminophen with Codeine #3 Hydrocodone Bit/ Acetaminophen Oxycodone HCl/Acetaminophen 5/500 Oxycodone HCl/ Acetaminophen

* Selected drugs are copied from Numbered Memorandum 05-05 HRSA.

Over-the-counter, non-prescribed contraceptive supplies (e.g., condoms, spermicidal foam, cream, gel, etc.,) may also be obtained in a 30-day supply through a pharmacy or a family planning provider with a Medical ID card.

Hormonal Contraceptives Dispensed from HRSA-Approved Family Planning Clinics:

For fee-for-service clients, hormonal contraception must be dispensed at a minimum of three cycles/months. A maximum of 13 cycles may be dispensed on the same day. If the hormonal contraception is dispensed for less than three months/cycles, there must be documentation in the chart stating the reason the why only one or two cycles were dispensed.

Hormonal Contraceptive Prescriptions filled at the pharmacy.

HRSA's Point-of-Sale system currently cannot fill a contraception prescription for more than a three month supply at one time. We are working on system changes to allow refills for up to a 12 month supply. Until further notice, you must dispense three months/cycles unless the prescriber writes a prescription for less than three months/cycles.

Managed care clients will receive their hormonal contraceptives according to the terms set by their managed care plans.

Note: All services provided to TAKE CHARGE clients **must** have a primary focus and diagnosis of family planning (i.e., ICD-9-CM diagnosis code within the V25 series, excluding V25.3). All services related to sterilization must be billed with the sterilization diagnosis code V25.2

What services are *not* covered? [WAC 388-532-750]

HRSA does not cover medical services under the TAKE CHARGE program unless those services are:

- Performed in relation to a primary focus and diagnosis of family planning; and
- Medically necessary for the client to safely, effectively, and successfully use, or continue to use, his or her chosen contraceptive method.

Abortions are not covered under the TAKE CHARGE program.

Other pregnancy-related services are not covered under the TAKE CHARGE program.

Note: The purpose of the TAKE CHARGE program is to prevent unintended pregnancies. **All services provided under TAKE CHARGE must be related to the prevention of unintended pregnancy.**

Inpatient Services: HRSA does not cover inpatient services under the TAKE CHARGE program. However, inpatient costs may be incurred as a result of complications arising from covered TAKE CHARGE services. If this happens, providers of TAKE CHARGE related inpatient services must submit to HRSA a complete report of the circumstances and conditions that caused the need for the inpatient services in order for HRSA to consider payment under WAC 388-501-0165. A complete report includes:

- A copy of the billing (UB-92, HCFA-1500);
- Letter of explanation;
- Discharge summary; and
- Operative report (if applicable).

Fax the complete report to HRSA Division of Medical Benefits and Care Management at 360.586.1471.

Reimbursement

[Refer to WAC 388-532-550, WAC 388-530-1425, and WAC 530-1700(4)]

Fee Schedule: HRSA limits reimbursement under the TAKE CHARGE program to visits and services listed on the Fee Schedule (see section D) that:

- Have a primary focus and diagnosis of family planning as determined by a qualified, licensed medical practitioner (i.e., ICD-9-CM diagnosis code within the V25 series); and

- Are medically necessary for the clients to safely, effectively, and successfully use, or continue to use, their chosen contraceptive method.

Department-Approved Family Planning Clinics that Dispense Contraception:

Must comply with WAC 388-530-1700(4) Pharmacy Services.

- **For services**: Bill HRSA your *usual and customary fee* (the fee you bill the general public). HRSA's payment is either your *usual and customary fee* or HRSA's maximum allowable fee, whichever is less.

- If a HRSA fee schedule lists a drug or item as "actual acquisition cost," the provider must bill its actual acquisition cost and not a usual and customary fee or maximum allowable fee.

- **For drugs purchased under the Public Health Services (PHS) Act**: Providers must comply with Pharmacy Services WAC 388-530-1425.

WAC 388-530-1425
(1) Drugs purchased under section 340B of the Public Health Service (PHS) Act can be dispensed to medical assistance clients only by PHS-qualified health facilities. These medications must be billed using the actual acquisition cost (AAC) of the drug plus the appropriate dispensing fee.

(2) Providers dispensing drugs under this section are required to submit their valid MAA provider number(s) to the PHS Health Resources and Services Administration, Office of Pharmacy Affairs. This requirement is to ensure that claims for drugs dispensed under the Public Health Service (PHS) Act and paid by **HRSA** are excluded from the drug rebate claims that are submitted to the manufacturers of the drugs.

- **For other contraceptives, drugs, drug supplies and devices not purchased under Public Health Services Act:** Bill HRSA your usual and customary fee. Reimbursement is your usual and customary fee or the department's maximum allowable fee, whichever is less. [Refer to WAC 388-530-1050]

- Any non-contraceptive take-home drugs dispensed at a family planning clinic are not reimbursable.

Research and Evaluation Activities: HRSA limits reimbursement for TAKE CHARGE to selected research sites.

FQHC/RHC: Federally qualified health centers (FQHCs), rural health clinics (RHCs), and Indian health providers who choose to become TAKE CHARGE providers must bill HRSA for TAKE CHARGE services without regard to their special rates and fee schedules. HRSA does **not** pay FQHCs, RHCs, or Indian health providers under the encounter rate structure for TAKE CHARGE services.

Billing Timeline: HRSA requires TAKE CHARGE providers to meet the billing requirements of WAC 388-502-0150 (billing time limits). In addition, billing adjustments related to the TAKE CHARGE program must be completed no later than two years after the demonstration and research program terminates. HRSA will not accept any new billings or any billing adjustments that increase expenditures for the TAKE CHARGE demonstration and research program after the cut-off date in this WAC.

Third-Party Liability: HRSA requires a provider under WAC 388-501-0200 to seek timely reimbursement from a third party when a client has available third party resources. See page E.8 for exceptions to this requirement.

Family Planning Services Coverage Table

Note: For billable codes and fees for Reproductive Health Services, refer to the *Physician-Related Billing Instructions*. Only the provider who rendered the services is allowed to bill for those services, except in the case where a client self-refers outside the HRSA Managed Care Plan for family planning services.

Office Visits

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
99201		Office/outpatient visit, new		
99202		Office/outpatient visit, new		
99203		Office/outpatient visit, new		
99204		Office/outpatient visit, new		
99211		Office/outpatient visit, est		
99212		Office/outpatient visit, est		
99213		Office/outpatient visit, est		
99214		Office/outpatient visit, est		
G0101		CA screen; pelvic/breast exam		

Comprehensive Family Planning Preventive Medicine Visits

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
99384		Adolescent (age 12 through 17)		New (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99385		18-39 years		New (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99386		40-64 years		New (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.

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Comprehensive Family Planning Preventive Medicine Visits (Continued)

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
99394		Adolescent (age 12 through 17)		Established (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99395		18-39 years		Established (female) patient Once every 11-12 months. Only TAKE CHARGE providers can bill.
99396		40-64 years		Established (female) patient - Once every 11-12 months. Only TAKE CHARGE providers can bill.

Prescription Birth Control Methods

Procedure Code	Modifier	Brief Description	EPA/ PA	Policy/ Comments
Oral Contraceptives				
S4993		Contraceptive pills for birth control		[1 unit = each 30-day supply] (*Seasonale* should be billed as 3 units.) Must be billed with S9430 (i.e., one unit of S4993 is entitled to one unit of S9430).

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S9430		Pharmacy compounding and dispensing services		HRSA pays for a dispensing fee for each unit billed with S4993, J7303, J7304 and J3490. (Plan B).
Note: • The dispensing fee can be billed only for designated drugs which must be purchased and dispensed by an HRSA-Approved Family Planning Provider. • The dispensing fee can be billed only for drugs **purchased** by the provider. Any drug provided free of charge (e.g., samples, those obtained through special manufacturer agreements, etc.) is not reimbursable. A dispensing fee in these cases is not reimbursable either. • The dispensing fee can be billed on a unit-by-unit basis only with codes S4993, J7303, J7304, and J3490 (Plan B). For example, if the provider dispenses 12 units of S4993 and 1 unit of J3490 (Plan B), then the dispensing fee (S9430) would be billed for 13 units. The number of billed units for S9430 must **always** equal the number of units dispensed by the provider for codes S4993, J7303, J7304 and/or J3490 (Plan B).				
Cervical Cap/Diaphragm				
A4261		Cervical cap for contraceptive use		
A4266		Diaphragm		
57170		Fitting of diaphragm/cap		
Implant				
11976		Removal of contraceptive capsule		
Injectables				
J1055		Medroxyprogesterone acetate inj for contraceptive use, 150 mg *(Depo-Provera)*		Allowed once every 67 days.
90772		Ther/proph/diag inj, sc/im (Specify substance or drug)		May not be billed with an office visit.
Intrauterine Devices (IUD)				
J7300		Intrauterine copper device *(Paragard)*		
J7302		Levonorgestrel-releasing IUD *(Mirena)*		
58300		Insertion of intrauterine device (IUD)		
58301		Removal of intrauterine device (IUD)		

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Prescription Birth Control Methods (Continued)

Procedure Code	Modifier	Brief Description	EPA/ PA	Policy/ Comments
Miscellaneous Contraceptives				
J7303		Contraceptive ring, each *(Nuvaring)*		Must be billed with S9430 (i.e., one unit of J7303 is entitled to one unit of S9430)
J7304		Contraceptive patch, each *(Ortho-Evra)*		Must be billed with S9430 (i.e., one unit of J7304 is entitled to one unit of S9430) One patch = one unit.

Non-Prescription Over-the-Counter (OTC) Birth Control Methods

Procedure Code	Modifier	Description	EPA/PA	Policy/ Comments
A4267		Male Condom, each		
A4268		Female Condom, each		
A4269		Spermicide (e.g. foam, sponge), each		e.g. includes gel, cream and vaginal film

Note: HRSA pays for most FDA-approved family planning products and supplies.

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Unlisted Contraceptive Drugs and Supplies

When billing for a contraceptive drug or contraceptive supply that does not have a dedicated HCPCS or CPT code, providers must bill HRSA for the contraceptive using HRSA's Expedited Prior Authorization (EPA) process.

The EPA process allows HRSA to use a nine-digit EPA number to identify, track, and appropriately pay for an unlisted contraceptive. The nine-digit EPA number must be listed in the "Prior Authorization Number" field of the claim form (for example, Box 23 of a HCFA-1500 claim form).

The first five digits of all HRSA EPA numbers are **87000**. The last four digits of the EPA number identify the exact contraceptive supplied.

Note: HRSA requires HRSA-approved Family Planning providers to list the 11-digit National Drug Code (NDC) number in the appropriate field on the claim form (see numbered memorandum 06-06 for details) when billing for **ALL** drugs administered in or dispensed from the family planning clinic.

Family Planning Clinics may no longer bill HRSA for an unlisted contraceptive drug or supply using J3490 or J3490-FP *without an EPA number*. If HRSA has not yet established an EPA number for a particular contraceptive drug or supply, contact the Family Planning or TAKE CHARGE program manager to have an EPA number established for the new product. (See *Important Contacts* on page iv.)

HRSA has established coding and EPA number requirements for the contraceptive drugs and supplies listed in the following tables.

Emergency Contraceptive Pills

Providers must bill HRSA for emergency contraceptive pills as detailed below:

HCPCS Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
J3490	FP	Unlisted drug	870001252	Use for Plan B only; and Each 1 unit equals one treatment Must be billed with S9430. (i.e., one unit of J3490 is entitled to one unit of S9430)

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Non-Drug Contraceptive Supplies

Providers must bill HRSA for unlisted non-drug contraceptive supplies as detailed below:

HCPCS Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
T5999	FP	Unlisted supply	870001253	Use for: Cycle beads only; and Each 1 unit equals one set of cycle beads
99071	FP	Unlisted supply	N	Use for: Natural family planning booklet only; and Each 1 unit equals one booklet.
A4931	FP	Reusable, oral thermometer	870001254	Use for: Basal thermometer only; and Each 1 unit equals one thermometer.

Note: Do **not** use these EPA numbers when billing for any contraceptive or drug other than those listed in the table above.

Sterilization Procedures

A properly completed Sterilization Consent Form, DSHS 13-364, **must** be attached to any claim submitted with any of the following procedure codes. Go to the link below to download form DSHS 13-364. http://www1.dshs.wa.gov/pdf/ms/forms/13_364a.pdf.

Procedure Code	Modifier	Brief Description	EPA/ PA	Policy/ Comments
00840	As needed	Anesthesia for intraperitoneal procedures in lower abdomen		
00851	As needed	Anesthesia for intraperitoneal procedure/tuballigation		
55250		Removal of sperm duct(s)		

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Sterilization Procedures (Continued)

Procedure Code	Modifier	Brief Description	EPA/ PA	Policy/ Comments
55450		Ligation of sperm duct		
58600		Division of fallopian tube		
Laparoscopy				
58615*		Occlude fallopian tube(s)		HRSA pays for external occlusive devices **only** such as band, clip, or *Falope* ring. HRSA does not pay for occlusive devices introduced into the lumen of the fallopian tubes. (i.e., *Essure*)
58670		Laparoscopy, tubal cautery		
58671*		Laparoscopy, tubal block		HRSA pays for external occlusive devices **only** such as band, clip, or *Falope* ring. HRSA does not pay for occlusive devices introduced into the lumen of the fallopian tubes (i.e., *Essure*)

Note: Sterilization procedures and any initial visits must be billed with ICD-9-CM diagnosis code V25.2.

Radiology Services

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
77080		Dual energy x-ray absorptiometry (DXA)		See Fee Schedule in Physician-Related Services Billing Instructions (BI) Covered only for clients according to standards of care for clients using or considering *Depo-Provera.*
77081		Radius, wrist-heel		See Fee Schedule in Physician-Related Services BI Covered only for clients according to standards of care for clients using or considering *Depo-Provera.*

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Radiology Services (Continued)

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
76830		Ultrasound, transvaginal		
76830	26	Professional Component		
76830	TC	Technical Component		
76856		Ultrasound, pelvic, complete		
76856	26	Professional Component		
76856	TC	Technical Component		
76857		Ultrasound, pelvic, limited		
76857	26	Professional Component		
76857	TC	Technical Component		
76977		Ultrasound bone density measurement and interpretation, peripheral site(s)		See Fee Schedule in Physician-Related Services BI Covered only for clients according to standards of care for clients using or considering *Depo-Provera.*

Note: Radiology services must be performed by radiologists. HRSA pays radiologists for these services.

Laboratory Services

A family planning provider may bill for laboratory services only when the provider actually performs lab tests unless the client is a self-referred HRSA managed care client. Only in this instance, with managed care clients, may a family planning provider bill HRSA for laboratory services on a "pass-through" basis and only up to the amount billed by the laboratory.

Procedure Code	Modifier	Brief Description	EPA/ PA	Policy/ Comments
36415		Drawing blood venous		Payment limited to one draw per day.
36416		Drawing blood capillary		
80061		Lipid profile		
80076		Hepatic function panel		
81000		Urinalysis, nonauto w/scope		

Laboratory Services (Continued)

Procedure Code	Modifier	Brief Description	EPA/ PA	Policy/ Comments
81001		Urinalysis, auto w/scope		
81002		Urinalysis nonauto w/o scope		
81003		Urinalysis, auto, w/o scope		
81025		Urine pregnancy test		
82120		Amines, vaginal fluid, qualitative		
82465		Assay, bld/serum cholesterol		
83718		Lipoprotein, direct measurement; high density cholesterol (HDL)		
84132		Potassium; serum		
84146		Prolactin		
84443		Thyroid stimulating hormone (TSH)		
84703		Chorionic gonadotropin assay		
85013		Hematocrit		
85014		Hematocrit		
85018		Hemoglobin		
85025		Automated hemogram		
85027		Automated hemogram		
86255		Fluorescent antibody, screen		
86255	26	Professional Component		
86631		Chlamydia antibody		
86632		Chlamydia igm antibody		
86692		Hepatitis, delta agent		
86706		Hep b surface antibody		
87110		Chlamydia culture		
87140		Cultur type immunofluoresc		
87147		Culture type, immunologic		
87210		Smear, wet mount, saline/ink		
87270		Infectious agent antigen detection by immuno-fluorescent technique; chlamydia trachomatis		

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Laboratory Services (Continued)

Procedure Code	Modifier	Brief Description	EPA/ PA	Policy/ Comments
87320		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative; chlamydia trachomatis		
87340		Hepatitis b surface ag, eia		
87490		Chylmd trach, dna, dir probe		
87491		Chylmd trach, dna, amp probe		
87590		N.gonorrhoeae, dna, dir prob		
87591		N.gonorrhoeae, dna, amp prob		
87810		Chylmd trach assay w/optic		
88141		Cytopath, c/v, interpret		
88142		Cytopath, c/v, thin layer		
88143		Cytopath, c/v, thin lyr redo		
88147		Cytopath, c/v, automated		
88148		Cytopath, c/v, auto rescreen		
88150		Cytopath, c/v, manual		
88152		Cytopath, c/v, auto redo		
88153		Cytopath, c/v, redo		
88154		Cytopath, c/v, select		
88164		Cytopath tbs, c/v, manual		
88165		Cytopath tbs, c/v, redo		
88166		Cytopath tbs, c/v, auto redo		
88167		Cytopath tbs, c/v, select		
88174		Cytopath, c/v auto, in fluid		
88175		Cytopath, c/v auto fluid redo		
88300		Level 1 surgical pathology, gross examination only		
88302		Tissue exam by pathologist, level II		
88302	26	Professional Component		
88302	TC	Technical Component		

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Injectable Drugs and Injection Fee

(These drugs are given in the family planning clinic. These are not take-home drugs or drugs obtained by prescription through a pharmacy.) The following drugs are the only ones paid to department-approved family planning clinics. All other covered drugs, must be obtained and billed by a pharmacy, see page C.20. See numbered memoranda 06-06 for more NDC details.

Procedure Code	Modifier	Brief Description	EPA/ PA	Policy/ Comments
90772		Ther/proph/diag inj, sc/im (Specify substance or drug)		May not be billed with an office visit.
J0456		Azithromycin inj, 500 mg		
J0580		Penicillin g benzathine inj		
J0690		Cefazolin sodium inj, 500 mg		
J0694		Cefoxitin sodium inj, 1 g		
J0696		Ceftriaxone sodium inj, 250 mg		
J0697		Sterile cefuroxime inj, 750 mg		
J0698		Cefotaxime sodium inj, per gram		
J0710		Cephapirin sodium inj, up to 1 g		
J1055		Medroxyprogesterone acetate inj *(Depo-Provera)*		Allowed once every 67 days.
J1890		Cephalothin sodium inj, up to 1 g		
J2460		Oxytetracycline inj, up to 50 mg		
J2510		Penicillin g procaine inj, to 600,000 u		
J2540		Penicillin g potassium inj, to 600,000 u		
J3320		Spectinomycn di-hcl inj, up to 2 g		
Oral Medication				
Q0144		Azithromycin dihydrate, oral, 1 g		
J3490	FP	Unlisted drugs	870001 252	Use for: Plan B only; and Each 1 unit equals one treatment Must be billed with S9430.

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TAKE CHARGE Clients Only

HCPCS Code	Modifier	Brief Description	EPA/ PA	Policy/ Comments
T1023	FP	Intake Assessment		(Use for application assistance) *Only for TAKE CHARGE clients* Once every 12 months
99401	FP	PT education noc individ		(Use for Male contraceptive counseling – ECRR) *Only for TAKE CHARGE clients.* Once every 12 months

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Fee Schedule

You may view **HRSA-Approved Family Planning Providers Fee Schedule** on-line at

http://maa.dshs.wa.gov/RBRVS/Index.html

For a paper copy of the fee schedule:

- **Go to:** http://www.prt.wa.gov/ (On-line orders filled daily.) Click **General Store**. Follow prompts to **Store Lobby → Search by Agency → Department of Social and Health Services → Health and Recovery Services Administration →** desired document; **or**

- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/ telephone 360.586.6360. (Telephoned or faxed orders may take up to 2 weeks to fill.)

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